STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. N-12/13-870
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Disabilities, Aging and Independent Living (DAIL) finding that she neglected a vulnerable adult. The issue is whether DAIL established by a preponderance of the evidence that petitioner's actions constitute neglect as that term is defined in 33 V.S.A. § 6902(7).

Background and Procedural History

Petitioner filed for a fair hearing on December 4, 2013. Several status conferences were held, during which petitioner indicated she would like to find legal representation for her appeal. She ultimately decided to proceed *pro se*, and a hearing was scheduled along with a pre-hearing schedule for exchanging witness lists and filing any preliminary motions. On April 11, 2014, DAIL filed a motion *in limine* requesting that the Board exclude the testimony of several witnesses listed by petitioner because it appeared those witnesses would testify solely about petitioner's character. By a memorandum from the Hearing Officer dated May 8, 2014, DAIL

and petitioner were advised that DAIL could raise its objections to petitioner's witnesses at the hearing.

An evidentiary hearing was held in Newport on May 13, 2014. DAIL presented testimony from (1) MB, the vulnerable adult who received care from petitioner, (2) SE, another LNA who cared for MB, (3) HC, a Licensed Practical Nurse for the Meeting Place in Newport, (4) JB, Director of the Meeting Place, and (5) DB, an Adult Protective Services investigator. Petitioner, who represented herself with assistance from JL, testified on her own behalf.

DAIL's Investigation Summary was admitted into the evidentiary record, and petitioner's copy of the Investigation Summary, which she received from DAIL and which was in a different format, was also admitted into the record.

The decision is based on the evidence adduced from testimony and the exhibits admitted during the hearing.[1]

[1] The Investigation Summary documents that DAIL conducted an investigation. The substance of the summary is the investigator's interviews of the witnesses who testified at hearing. Accordingly, the Findings of Fact in this Decision are primarily based on the testimony provided by the witnesses at the hearing.

FINDINGS OF FACT

1. Petitioner, an employee of BAYADA, a home health agency serving the Newport area, was responsible for providing personal and companionship care for MB from May 2012 until she terminated her employment with BAYADA in August of 2013.

2. MB is presently sixty-eight years old, and was sixty-seven years old when she received care from petitioner. MB has disabilities that include mental illness in the form of chronic schizophrenia, she uses a urostomy bag for collecting urine, she's had a hip replacement and she requires a wheelchair because she is unable to walk.

3. MB's urostomy bag typically needs to be replaced three days a week, but if she engages in activities in which she moves more, even while in her wheelchair, the urostomy bag may need to be replaced more frequently.

4. MB lives alone in Newport Senior Housing and receives visits from LNAs employed by BAYADA who are tasked with helping her with her personal care needs, including cooking, washing dishes, laundry, and vacuuming. The LNAs also help MB with bathing, often in the form of sponge baths, changing her clothes and helping her replace her urostomy

bags once they are full, but only when MB agrees to help with these hygiene-related tasks.

5. MB requires a nursing home level of care on some days, but not all of the time.

6. When petitioner started providing assistance and care for MB in May of 2012, she was assigned to work a shift on Wednesday evenings. Petitioner later picked up several morning shifts. Starting in May 2013, petitioner was assigned to the morning shift seven days a week, and she continued to work the evening shift on Wednesday. Petitioner was assigned to one and one half hour shifts in the mornings, from 7:00 or 7:30 a.m. to 8:30 or 9:00 a.m. Petitioner's Wednesday shift was from 3:00 to 9:00 p.m. Petitioner also worked an overnight shift as an LNA at another facility from 10:00 p.m. to 6:00 a.m.

7. During the morning shift, petitioner's work duties included helping MB get ready to go to The Meeting Place, an adult day care facility in Newport. MB was admitted for visits to The Meeting Place in March 2011, and she goes to The Meeting Place five days a week on Monday, Tuesday, Thursday, Friday and Saturday. The Meeting Place provides meals and activities for elderly people and people with mental illnesses.

8. SE is an LNA who provided care for MB two to three days a week in the afternoon and/or evening during the same time period as petitioner. Her duties were the same as those of petitioner and other LNAs: clean the apartment, cook, make sure MB took her medicine, and if MB allowed it, provide her with hygiene care.

9. At some point MB and petitioner made an arrangement where petitioner would call MB in the morning to make sure she was up, and petitioner would sometimes ask MB if it was all right if she arrived late because she had to get her son on the school bus between her overnight shift and her morning shift with MB. Petitioner reported this arrangement to BAYADA.

10. There is evidence that petitioner may have missed morning shifts, but there is also evidence that petitioner worked the morning shifts on most days, and that she occasionally worked an unassigned evening shift when MB called her for help because the LNA assigned for that shift had not showed up.

11. When petitioner arrived late for a morning shift at MB's apartment, she would report less than a full hour of work on her timesheets to account for her late start.[2]

12. There were times when MB would tell petitioner "not to come the next day or that she didn't want [petitioner] there," and when that happened petitioner reported MB's directives to BAYADA.

13. When petitioner filled out her timesheets, she placed an "R" for "refused" next to personal care tasks that MB refused, and her timesheets were submitted to BAYADA every week.

14. Petitioner frequently reported to BAYADA that "[MB] had refused a lot of things that should have been done."

15. When petitioner believed that MB's personal care needs had increased, and she informed BAYADA that the hours of care for MB should be increased.[3]

16. A staff member from The Meeting Place observed petitioner at The Meeting Place a few times, however she was

[2] Petitioner's testimony raises questions as to why BAYADA would continue to schedule petitioner seven days a week when petitioner was reporting that she was sometimes late for her morning shift with MB.

[3] Petitioner's testimony that she requested increased hours of care for MB is consistent with SE's testimony that the plan of care for MB should have provided for more visits from BAYADA's nurses.

not sure whether petitioner had given MB a ride there or whether she had stopped by to visit MB.

17. When MB arrived at The Meeting Place, she might sit outside and smoke for as long as an hour and a half before entering the building. There is no dispute that even if MB had accepted hygiene care in the morning, her urostomy bag could leak or burst between the time she left her apartment and the time she entered the building.

18. When MB's urostomy bag burst, she would be more likely to accept hygiene care, but even in that circumstance, she would sometimes refuse such care and would not allow herself to be cleaned up or her clothes to be changed for a couple of hours.

19. When MB needed hygiene care, petitioner would offer to clean up MB, but MB would often refuse.[4] MB was adamant and clear about her frequent refusal of such care from petitioner and her other caregivers. Petitioner, along with all of the witnesses who provided care for MB at her home or at The Meeting Place, corroborated MB's testimony. All witnesses agreed that MB could not be forced to accept

[4] MB testified that petitioner "offered to do my hygiene and I refused."

hygiene care if she refused it. It is found that MB often refused hygiene care from petitioner and other caregivers.[5]

20. Because MB would often refuse hygiene care from petitioner and other caregivers, she would arrive at The Meeting Place with her hair disheveled, dirty clothes and a bad odor.

21. In August 2013, MB told staff at The Meeting Place that she didn't "get help always in the morning." Based on MB's report and her arrivals at The Meeting Place with dirty clothes and a bad odor, the staff conveyed MB's complaint to BAYADA. Nevertheless, MB continued to have hygiene problems, and according to staff from The Meeting Place, those problems continue to this day.

22. On August 9, 2013, DAIL's Division of Licensing and Protection received a report that MB was being neglected by petitioner, and an investigation was initiated by Adult Protective Services.

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[5] When asked if, when she went to The Meeting Place, people were telling her she was not cleaned up like she was supposed to be, MB responded "it was offered and I refused…she offered, but I said no." When asked to clarify, MB testified that "[petitioner] offered to do my hygiene, and I refused." MB continued, "I would let her comb my hair, but that was about it . . . I was a bad girl, I wouldn't do anything for anybody, . . . no matter how many people told me." And when asked if she told staff at The Meeting Place that she was not always getting assistance in the morning, MB responded, "I did, but it was because I refused it . . . it wasn't because they didn't give it to me . . . [petitioner] would have given me a sponge bath, but most of the time back then, I just said 'no, I don't want it.'"

23. Following the report to DAIL, BAYADA informed petitioner that she was the subject of allegations regarding her care of MB, that she was no longer assigned to care for MB, and BAYADA instructed her not to speak with MB.

24. After hearing about the allegations regarding her care of MB, petitioner resigned from her employment with BAYADA.

25. After petitioner stopped providing care for MB, MB continued to show up at The Meeting Place without having received proper hygiene care.

26. HC, an LPN at The Meeting Place, testified that staff had talked to BAYADA on many occasions about MB's hygiene, but "it has been an ongoing problem and it continues to this day."

27. JB, the Director of The Meeting Place, credibly testified that MB had experienced hygiene problems for the past three and a half years.

28. The Meeting Place had a meeting with MB in September 2013 to discuss her hygiene care. HC and JB attended the meeting, along with a nurse and a caregiver from The Meeting Place, a representative from the Agency on Aging, and a representative from BAYADA.

29. At the September meeting, MB stated that she refused care from all of her LNAs. Regarding that meeting, MB credibly testified "that meeting wasn't for [petitioner], that meeting was to whip me into taking care of myself . . . hygiene-wise." MB also credibly testified she was told "if I didn't start keeping myself cleaned up . . . I wouldn't be able to go . . . to The Meeting Place."

30. MB still sometimes refuses hygiene care from her caregivers.

31. DAIL presented evidence of petitioner missing morning shifts through the testimony from another caregiver, SE, who stated that she observed petitioner's timesheets in the folder where all timesheets were kept at MB's apartment. On one occasion SE saw hours listed for time she believed petitioner had not worked because dishes washed during a previous shift had not been put away. SE's testimony on this point is based on speculation and assigned no weight.

32. DAIL also presented evidence of petitioner missing morning shifts through the testimony from JB, who stated that when MB arrived at The Meeting Place with soiled clothing and poor body odor, JB knew that either somebody was not there (at MB's apartment) or that MB had not been taken care of. In light of the evidence that MB often refused hygiene care,

JB's testimony on this point is speculative and assigned no weight.

ORDER

DAIL's decision to substantiate petitioner for neglect of a vulnerable adult is reversed.

REASONS

By statute, the Commissioner of DAIL is required to investigate allegations of neglect of vulnerable adults, and to keep the cases that are substantiated in a registry under the name of the person who committed the neglect. 33 V.S.A. §§ 6906 and 6911(b). The law's purpose is to "protect vulnerable adults whose health and welfare may be adversely affected through abuse, neglect or exploitation". 33 V.S.A. § 6901. It is undisputed that MB is a vulnerable adult under the definition of 33 V.S.A. § 6902(14)(D)(i).

Once DAIL substantiates neglect of a vulnerable adult, the person who has been substantiated may apply to the Human Services Board for relief. 33 V.S.A. § 6906(d). The hearing before the Board is *de novo*. DAIL bears the burden of proof to show by a preponderance of evidence that the petitioner's behavior in this case meets the criteria for neglect.

The definition for neglect is set out in 33 V.S.A. § 6902(7) as follows:

(7) "Neglect" means purposeful or reckless failure or omission by a caregiver to:

(A)(i) provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative. . .

(iii) carry out a plan of care for a vulnerable adult when such failure results in or could reasonably be expected to result in physical or psychological harm or a substantial risk of death to the vulnerable adult, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative. . .

(8) “Plan of care” includes but is not limited to, a duly approved plan of treatment, protocol, individual care plan, rehabilitative plan, plan to address activities of daily living or similar procedure described in the care, treatment or services to be provided to address a vulnerable adult’s physical, psychological or rehabilitative needs.

In this case, DAIL did not introduce sufficient evidence to establish that petitioner’s conduct rose to the level of neglect as contemplated by the statute. The evidence is insufficient primarily because it is undisputed that MB often refused hygiene care, not just from petitioner, but from her other caregivers as well. As shown in the above Findings of Fact, all of the caregiver witnesses who testified in this matter, as well as MB herself, were clear that MB has refused

hygiene care in the past, and her hygiene problems from refusing care continue to the present.

In addition, MB recalled the meeting at The Meeting Place during which she was told that she would have to accept hygiene care from her LNAs or she would no longer be welcome at The Meeting Place. MB was clear that the meeting took place *after* petitioner stopped providing her care. Her recollection is corroborated by other testimony establishing that petitioner stopped caring for MB in August, and the meeting at The Meeting Place did not take place until September.

Moreover, all of the witnesses agreed, and MB demonstrated that she understood, that she cannot be forced to accept hygiene care when she refuses it. This evidence further demonstrates that MB's refusal of hygiene care from petitioner was not unusual. Under such circumstances, petitioner was "acting pursuant to the wishes of the vulnerable adult" and her conduct was not neglect as contemplated under 33 V.S.A. § 6902(7).

While there is circumstantial evidence that petitioner may have missed some of her shifts, that evidence does not support the Department's decision. The evidence of missed shifts is primarily based on testimony of other witnesses

regarding hearsay statements made by MB. These statements were not corroborated by MB, who testified at the hearing herself and who, notwithstanding her mental illness, testified competently.[6] In addition, the testimony of Department witnesses SE and JB, that their observations of a house cleaning task not completed or MB's poor hygiene showed that petitioner missed a shift, is speculative and not entitled to any evidentiary weight.

Finally, petitioner's testimony about her communications with MB and reports she made to her employer shows an intent to keep MB apprised of her schedule and her employer informed of the care she was providing to MB, as well as any changes in MB's need for care. Petitioner's communications with MB and her reports to her employer are not consistent with conduct constituting neglect.

The Board notes that MB presents a challenging situation for her caregivers because of her refusals of hygiene care. It also appears that BAYADA has had ongoing problems with managing MB's care, and that those problems have not yet been

[6] To extent that MB did not remember particular conversations testified to by staff from The Meeting Place, the Department offered no records kept by those staff indicating the time, circumstances and details of such a conversation. Accordingly, it cannot be found that the time, content and circumstances of the hearsay statements of MB that were offered through The Meeting Place witnesses provide a substantial indicia of trustworthiness under Rule 804a(4) of the Vermont Rules of Evidence.

fully addressed. However, with respect to petitioner, the evidence in the record does not support a finding that her actions rise to the level of neglect as defined by 33 V.S.A. § 6902(7). Therefore DAIL's decision to substantiate petitioner for neglect of a vulnerable adult is reversed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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